January, 2018

Dear community physicians, practitioners, and providers of care to members of Kaiser Permanente
Health Plan of the Northwest,

The Northwest Permanente Medical Group (NWP) and Kaiser Foundation Health Plan of the
Northwest (KFHPNW) are accountable to provide you with information and resources in the
following areas of interest:

• Confidentiality.
• Member rights and responsibilities.
• Member-practitioner communication.
• Utilization Management.
• Pharmaceutical management procedures.
• Quality management and improvement.

We hope you find the information in this bulletin helpful and appreciate your help sharing it with
others at your practice site. Thank you for your attention to these policies and practices.

Sincerely,

Wui-Leong Koh, MD
Vice President
Quality
Northwest Permanente, PC

Nancy Louie Lee
Vice President
Quality and Service
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Confidentiality and protection of privacy policy

Kaiser Permanente employees and physicians are required to maintain the confidentiality of member and patient information, whether oral, written or electronic. This obligation is addressed in policies and procedures and confidentiality notices and agreements. All practitioners and providers with whom Kaiser Permanente contracts are subject to the Privacy and Security Program's confidentiality requirements. Kaiser Permanente has developed and distributed to members a Notice of Privacy Practices (NPP) describing members’ privacy rights and Kaiser Permanente’s obligation to protect their health information. The Notice of Privacy Practices is available online at https://healthy.kaiserpermanente.org/oregon-washington/privacy-practices

As described in the NPP, Kaiser Permanente will not disclose protected health information without written authorization, except as required or permitted by law. If the member or patient is unable to provide authorization, his or her legally authorized representative may provide authorization for the disclosure of information on the member’s or patient’s behalf. Member- or patient-identifiable protected health information may be shared with others including employers only with the member’s or patient’s permission or as otherwise required or permitted by law.

Members and patients have the right to see or receive copies of their own protected health information, and they have the right to authorize the disclosure of their own protected health information to others, or to request an accounting of certain disclosures of their protected health information, in accordance with applicable state and federal laws. Kaiser Permanente may collect, use, and share protected health information for treatment, payment, and health operations and for other routine purposes as permitted by law, for example, for use in quality improvement activities.
Member rights and responsibilities

At Kaiser Permanente, we believe that maintaining good health is a very important part of your well-being. Providing the quality health care necessary to maintain your good health requires building a partnership between you and your health care professionals.

You need information to make appropriate decisions about your care and lifestyle choices. Your health care professionals need your involvement to ensure you receive appropriate and effective health care. Mutual respect and cooperation are essential to this partnership.

It is important for you to know what you can expect and what we need from you when you receive care at Kaiser Permanente.

Members rights

At Kaiser Permanente, you have the right to:

- Receive information about Kaiser Permanente, our services, our health care practitioners and providers, and your rights and responsibilities.
- Be treated with consideration, compassion, and respect taking into account your dignity and individuality, including privacy in treatment and care without regard to your race, religion, ethnicity, color, national origin, cultural background, ancestry, language, gender, gender identity, gender expression, sex, sexual orientation, marital status, physical or mental disability, genetic information, age, or financial status.
- Be supported in selecting and changing clinicians and seeking a second opinion within our plan.
- Participate with practitioners in making decisions about your health care.
- Receive full information about your care, including a candid discussion of appropriate or medically necessary treatment options for your conditions; the benefits, risks and alternatives of recommended treatments or procedures regardless of cost or coverage; and realistic alternatives when hospital care is no longer appropriate. We'll provide information in a way you can understand and provide an interpreter if you need one.
- Receive assistance when you face difficult medical ethics issues by arranging consultations with members of our ethics services staff.
- Be supported if you change your mind about any procedure, refuse treatment or decline to participate in medical training programs or research projects, and inform you of the consequences of your refusal.
- Be respected for your right to personal privacy and your right to make decisions about your future.
- Give instructions about what is to be done if you are not able to make medical decisions for yourself. The legal documents that you can use to give your directions in advance are called “advance directives”.
- Timely access to your covered services and drugs. As a plan member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
- Be transferred only when medically appropriate and when the receiving facility is ready to accept you.
- Receive the names, professions, and educational backgrounds of the people treating you.
• Expect that the confidentiality of all personal health information, communications, and records regarding your care are protected. This information will not be released to any person or entity not affiliated with Kaiser Permanente without your prior authorization. We may make exceptions to this policy only when the release of information is authorized by law or when the information is to be used for quality improvement activities, bona fide research, or statistical reporting. You may review and obtain copies of your medical or dental records, unless restricted by law or when detrimental to your own well-being. If you think part of your medical record is incorrect, you may add a statement listing your objections and corrections.

• Receive a response in an appropriate, confidential, and timely manner to any concerns you have about your care or services provided, without sanction or reprisal. Membership Services will inform you of member satisfaction procedures and resources available to assist you.

• Be informed of business relationships between your Health Plan and others — health care providers, educational institutions, insurer — that may influence your treatment and care.

• Receive information about charges and payment methods. We will provide an itemized statement of non-covered services upon request, for an additional service charge.

• Voice your complaints freely without fear of discrimination or retaliation. If you are not satisfied with how your complaint was handled, you may have us reconsider your complaint.

• Make recommendations regarding Kaiser Permanente’s Member Rights and Responsibilities policy.

Members responsibilities

At Kaiser Permanente, you have the responsibility to:

• Follow the treatment plan agreed on by you and your health care practitioner. You have a responsibility to inform your health care practitioner if you do not understand or cannot follow through with your treatment and to let your health care practitioner know if changes need to be made.

• Improve the quality and safety of your care by providing accurate and complete information about your medical history, medications, and any changes in your condition.

• Understand your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible. Ask questions if you do not understand any aspect of your medical or dental condition or treatment.

• Be aware of the daily lifestyle decisions that affect your health, and that the choices you make can reduce the risks to your health and the health of your family.

• Tell your health care team if you are satisfied or dissatisfied with any aspect of your care.

• Provide your family, health care practitioner, and hospital with a copy of any advance directive you wish Kaiser Permanente to follow, should you be unable to make your own decisions.

• Treat your health care team with consideration and respect.

• Treat other patients with consideration and respect. When you are in the hospital, avoid having the volume on television sets too loud, having too many visitors, or holding loud conversations that may disturb other patients.

• Comply with the no-smoking, no-weapons, and visiting-hours policies.

• Be familiar with your health care benefits.

• Tell us if you have any other health insurance coverage or prescription drug coverage in addition to our plan. Please call Member Services to let us know.

• Tell us if you move. If you are going to move, it is important to tell us right away.

• Have your membership ID card handy when you call for an appointment or advice, or when you come in for care.

• Notify Kaiser Permanente in advance if you will be late for, or have to cancel, an appointment.

• Pay your bills on time and pay your copayments when you come in for care.
Member-practitioner communication

A basic value of Kaiser Permanente is that members and patients are to be treated fairly, with sensitivity, dignity, respect and consideration. We believe quality health care includes a full and open discussion with each patient regarding all aspects of medical care and treatment alternatives without regard to benefit coverage limitations. We maintain confidentiality consistent with the policies set forth by Kaiser Permanente. Conforming to our long-standing values, KPNW allows open practitioner-patient communication regarding appropriate treatment alternatives, allows your participation in your treatment plan, and does not penalize practitioners for discussing medically necessary or appropriate care.

For more information on Members’ Rights & Responsibilities, go to kp.org/disclosures.
Pharmacy Program

The KPNW Regional Formulary and Therapeutics Committee (RFTC) oversees the management of the formulary in conjunction with Regional Pharmacy Services. This group reviews and maintains pharmaceutical management procedures and formulary determinations on an ongoing basis. The RFTC uses the formulary system and evidence-based decision making to determine which medications will be made available for practitioners to order for patients.

The Formulary

The Formulary is intended to enhance the quality of patient care by ensuring that available drugs meet established quality standards by providing information for safe and effective use and by limiting the availability of drugs that are unsafe, less effective, and ineffective or have high potential for toxicity or abuse.

Formulary drugs are drugs and biologic agents that have been reviewed by the RFTC and placed on the Formulary. Non-formulary drugs are drugs which have not yet been reviewed or which were reviewed but not accepted for inclusion in the Formulary.

The Formulary is available to all clinicians and Health Plan staff via the internal KPNW Pharmacy Department website. All members and contract providers can access the Formulary via the kp.org website: https://prospectivemembers.kp.org/kpweb/entryPage.do?cfe=422

Individuals without Internet access may request print copies by contacting Pharmacy Services at 503 261-7900, toll free at 1-888-572-7231.

All KPNW Physicians and Allied Health providers who are licensed to prescribe pharmaceuticals in the state of Oregon or Washington may prescribe Formulary drugs without restriction.
The RFTC reviews medications for addition to or deletion from the formulary on a monthly basis. Any practitioner or member may request that a drug or dosage form be added to or deleted from the formulary.

Practitioners may do so by completing a Drug Formulary Change Request form by contacting Pharmacy Services via phone at 503-261-7900, toll free at 1-888-572-7231.

Members requesting a formulary change will be directed to the Member Relations Department to submit a formal request that will be reviewed through the medical necessity determination process and, if approved, through the RFTC review process.

Drug selection decisions are made primarily based on safety and effectiveness. Safety and effectiveness are determined by a thorough review of pertinent medical evidence, incorporating expert opinion and relevant findings from appropriate external organizations. After safety and effectiveness are investigated, cost is considered.

**Non-formulary Exception Process**

Drugs not on the KPNW Formulary are considered non-formulary, and are not covered by the drug plan, unless the prescribing clinician has determined the non-formulary medication to be medically necessary. [See UM Policy 13a for more information on the exception process]. The Non-Formulary Drug review process does not apply to drugs used for indications excluded by contract, or drugs used for non-covered services.


**Generic Substitution**

As drugs become available in generic form, they are reviewed by Pharmacy Services based on bioequivalence data provided by the Food and Drug Administration (FDA). Members demanding branded products for which there is a generic will pay the retail cost of the drug unless medically necessary as determined through the criteria-based prescribing review process. Pharmacists administer generic substitution as outlined in the Oregon and Washington State Boards of Pharmacy Laws.

**Therapeutic Equivalents**

Therapeutic Equivalent (TE) drugs produce essentially the same therapeutic outcome and have similar toxicity profiles. Usually these drugs are within the same pharmacological class or are different dosage forms of the same drug (i.e. tablet for capsule or half-tablet for full tablet of lesser strength). TEs are restricted to the list approved by the RFTC and updated annually. An annual TE List authorization signed and approved by the provider authorizes the pharmacist to perform therapeutic interchange for medications on the TE List.

**Prescribing Criteria/Step Therapy**

The RFTC has approved prescribing criteria to apply to selected medications. Medications classified as criteria-based/step therapy are usually second or third line medications for the treatment of a specific disease state. The RFTC uses both internal and external resources, including Specialty Department input, Food and Drug Administration recommendations and clinical trials published in the medical literature to guide them in the creation of prescribing criteria. [See UM Policy 13e for more information on criteria-based/step therapy].

Quantities

Standard prescription quantities are as defined by the drug benefit: a 30-day supply or unit of use per copayment or coinsurance at the clinic level, or a 90 day supply of maintenance medication for two (2) copayments from the mail order pharmacy as defined by the plan.

The 30/30 Benefit list places dispense quantity limitations on medications with a high potential for waste or diversion. Medications on this list, whether formulary or non-formulary, will be limited to no more than a 30-day supply at one time, even if the member’s drug benefit would normally provide a greater supply.

There are no limits on the number of prescriptions which may be prescribed per member, or number of refills other than those delineated by state and federal laws or per RFTC recognized therapeutic guidelines established by the FDA.

More Information/Contacting Pharmacy Services

For more information about the KPNW formulary process or other pharmaceutical management policies and procedures — including criteria-based consultation prescribing, copayment requirements, and any other restrictions and/or limitations — or to obtain a copy of the KPNW drug formulary, contact Pharmacy Services at 503-261-7900, toll free at 1-888-572-7231.
Access to care decisions and availability of utilization management criteria and guidelines

As a provider of service to KPNW members, you may be aware that Kaiser Foundation Health Plan of the Northwest (KFHPNW) and Northwest Permanente Medical Group (NWP) have jointly developed the Resource Stewardship (RS)/Utilization Review (UR) Program to monitor, evaluate, and guide decision making about the quality and cost of health care services delivered to all KPNW members.

The goal of the RS/UR Program is to ensure that care is delivered to KP members with consistent quality, safety, and efficiency, regardless of the location or service provider. Within the RS/UR Program, specially trained and designated staff conduct selected pre-service, concurrent, and retrospective review activities; monitor compliance with guidelines; and screen cases through the use of published and organizationally developed criteria. NWP physicians with expertise in utilization and quality activities consult with the UR staff as needed. The associate medical director of Resource Stewardship/Utilization Management has direct responsibility for implementation of the Utilization Management (UM) Program and provides oversight of day-to-day activities.

As a practitioner who may order medical items and services for Kaiser Permanente members, you and your patient are affected by decisions made through the application of utilization management review processes. Because of this involvement, it is important for you to have information about the UR Program that includes how decisions are made, how criteria are used to guide determinations of medical necessity, how to obtain a copy of specific criteria used, and how to contact appropriate staff regarding UM issues. The following information may be helpful.

UM decision making

The physicians and other health care staff of KPNW make medical necessity decisions based on the appropriateness of care and services for patients' medical needs and existence of coverage. KPNW does not compensate practitioners or other individuals responsible for utilization management decision making for issuing denials of coverage or service nor are decisions about hiring, pay, promotions, or termination of employment based on the likelihood that denials will be supported. No financial incentives exist that encourage decisions that result in denials or underutilization of coverage or service at KPNW. In order to maintain and improve the health of our members, all practitioners and health care staff should be especially vigilant in identifying any potential underutilization of care or service.
**UM criteria**

KPNW physicians are involved in developing criteria used to guide UM decisions and ensuring the criteria used are applied consistently in decisions to approve or deny services. Criteria are objective and based on medical evidence. Criteria and guidelines are used in conjunction with clinical judgment and case-specific consideration. Availability of services in the local delivery system and individual member needs (like age, co-morbidities, complications, psychosocial and cultural issues, home environment, patient safety, and community resources) are considered when making UM decisions. When applicable, clinical criteria or guidelines are referenced to guide UM decision making. The criteria used in the utilization review process are available to all practitioners upon request. Contact the Referral Coordinator at 503-813-4560.

**Contacting a UM physician reviewer**

A physician is required to review all services and items denied based upon medical necessity criteria or clinical judgment. The physician reviewer is available to discuss these denial decisions upon request. The contact information of the associate medical director of Resource Stewardship/Utilization Management or the NWP physician who rendered the determination is documented in the written denial notice.

It’s also possible to obtain the name and contact information of the reviewing physician associated with a specific denial by contacting Membership Services, Monday through Friday, between 8 a.m. and 6 p.m. In the Portland area, call 503-813-2000. From all other areas, call 1-800-813-2000. For TTY, call 1-800-735-2900. You can also e-mail Membership Services 24 hours a day, 7 days a week, by logging onto kp.org. A representative will make every attempt to respond to your inquiry the next business day.

To check on the status of a referral to an external practitioner, please contact the Regional Referral Center, Monday through Friday, between 8 a.m. and 5 p.m., by calling 503-813-4560. For internal referrals, contact the specific department who provides the service requested.
Patient Safety Program

Patient safety as defined; the freedom from unnecessary risk of harm associated with health care — is an integral component of Kaiser Permanente’s philosophy to provide quality health care that our members can trust. Kaiser Permanente Northwest Region (KPNW) incorporates patient safety into the everyday workings of the organization, guided by three principles:

- Patient Safety comes first.
- Patient Safety is every patient’s right.
- Patient Safety is every individual’s responsibility.

Patient safety is a key part of our health care delivery system, and it continues to be an important component of all our quality improvement programs. The program is designed to create and support a work environment that puts our members’ safety first. It includes developing and implementing appropriate systems, tools, and training guides to assist practitioners, providers, managers, supervisors, and frontline staff in their work of providing safe and effective care for our members. We promote the Institute of Medicine’s six dimensions of quality: safe, timely, effective, efficient, equitable, and patient-centered care.

KPNW and its network of providers and practitioners, managers, employees, and affiliates are responsible for patient safety. This responsibility guides individuals and health care teams in achieving excellent performance in safe and effective healthcare delivery.
The Kaiser Permanente vision is to be the safest system in which to receive and provide healthcare. To achieve this vision, our strategy is based upon our Safety Management System which focuses on the Reliability of the people and systems within; Accountability of our leaders, physicians, providers and employees to provide an environment of transparency and safety; and Resilience of individuals and the organization to recover from setbacks, adapt well to change and make improvements leading to safer systems of care.

We have a number of systems interventions in place aimed at improving our culture of safety and reducing the possibility of error. Some include:

- A regional-wide focus on a culture of safety that promotes proactive risk assessments and adverse event reporting by front line staff & providers supported by a Just Culture which identifies system and process failures while supporting individual accountability.

- Areas of focus:
  - **Medication Reconciliation** through our Transition in Care that ensures medications prescribed in the clinic and hospital settings are reconciled at each care transition to what the patient should be taking.
  - **Medication Adherence** which supports medication management and medication compliance for the patient.
  - **High Alert Medication Safety Program** that identifies certain high risk medications which carry a greater risk of harm due to nature of the medication and the route administered. This program ensures a set of safe medication management practices are in place prior to administering these medications.
  - **The use of Kaiser Permanente’s electronic medical record system** (KP HealthConnect) as a tool to trap potential errors that may otherwise affect patients. In addition, through KP HealthConnect, a “patient support tool” aids providers and health care teams in the identification of care gaps that may need to be addressed among the patients in the care team’s panels.
  - **Surgical/procedural safety**
  - **Adherence to the Joint Commission National Patient Safety Goals**, in our hospitals and clinic setting where applicable, with particular attention to encouraging patients’ active involvement in their own care as a patient safety strategy
  - **Continued participation in the Oregon Patient Safety Commission**
  - **Focus on the prevention** of serious adverse reportable events (SRAEs) and hospital acquired conditions (HACs)
Since 1995, the National Committee for Quality Assurance (NCQA) has accredited Kaiser Foundation Health Plan of the Northwest (KFHPNW). NCQA is a private, nonprofit organization dedicated to improving health care quality. NCQA accreditation helps health plans demonstrate their commitment to quality improvement and value, meet regulatory requirements, and distinguish themselves from the competition. KPNW’s last accreditation survey was in February of 2016. Our Medicare HMO achieved the highest accreditation status of Excellent and our Commercial HMO achieved the second-highest accreditation status of Commendable. This means we met or exceeded strict evaluation requirements in the areas of preventive measures, access and service, utilization management, physician credentialing, and quality including improvement. The next NCQA survey will be in 2019. The 2016 NCQA accreditation report is available online at kp.org/quality click on view independent reports.

NCQA Health Insurance Plan Ratings 2017-2018

NCQA’s Health Insurance Plan Ratings 2017–2018 lists private (commercial), Medicare and Medicaid health insurance plans based on their combined HEDIS®, CAHPS® and NCQA Accreditation standards scores. The NCQA Accreditation status used in these ratings are as of June 30, 2017 and published by NCQA in late September. Plan scores range from 0–5, in 0.5 increments, which is similar to the CMS Five-Star Quality Rating System. 2017 KPNW Commercial Accreditation dropped from Excellent to Commendable accreditation due to a decline in both HEDIS and CAHPS Performance. 2017 KPNW Medicare Accreditation remained at Excellent.

http://healthinsurancerratings.ncqa.org/2017/search/Commercial/OR/Kaiser

http://healthinsurancerratings.ncqa.org/2017/search/Medicare/OR/Kaiser
KPNW

Quality Program

Kaiser Permanente Northwest’s Quality Program seeks to improve the quality of both clinical care and services provided to the approximately 554,000 members it serves in Northwest Oregon and Southwest Washington. To that end, the program encompasses an extensive array of activities in collaboration with Kaiser Foundation Health Plan of Northwest (KFHP-NW), Northwest Permanente, P.C. (NWP), and Kaiser Foundation Hospitals (KFH) to support the regional strategic operating plan. Quality assessment and improvement is accomplished through a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and service provided (both internal and contracted) to our members including, but not limited to, the following:

- Monitoring clinical performance, care delivery systems, and the quality of care and service experienced by our members.
- Identifying and implementing improvement initiatives in the delivery of medical and behavioral health care services, patient safety, clinical risk management.
- Communicating clinical office and organizational performance results with health plan administrators, enabling them to make appropriate decisions to improve the quality and safety of care and services as well the appropriate management of resources.
- Complying with applicable regulatory and accrediting requirements

More information about the Quality Program including the annual quality program description, evaluation, and work plan can be obtained by contacting the Regional Quality Resource Management Department at 503-813-3810.

Clinical Quality

KPNW has many programs in place designed to promote high quality care and service. Objective, measurable indicators are developed to monitor important aspects of care and service within the region’s delivery system. Clinical departments and the organization as whole establish performance standards targets. Regional clinical performance is accounted for in the Health Plan Employer Data and Information Set (HEDIS). The annual Quality Program Evaluation contains key results and summaries of our performance on HEDIS as well as a variety of other quality initiatives, including chronic disease care management and measures. Year to date, as of September 2017, regional performance on KPNW’s high priority measures have improved over baseline on 16 of 28 measures, and 9 of 28 have already met or exceeded their 2017 targets. Of the measures remaining below target, 9 of 19 are within less than one percentage point of reaching target this year. The remaining ten measures that are greater than one percentage point from reaching their 2017 targets include: Childhood immunizations (combo 7), Well Child Visits Age 3-6 Years, CIS Flu Shots (2 doses), EVS recorded age 5-17, Diabetes HbA1c control <8, Cervical Cancer Screening, Colorectal Cancer Screening, Breast Cancer Screening, Osteoporosis management post fracture, and Timeliness of prenatal care. Increased efforts have been implemented to improve performance on these measures by the end of the year.

Service Quality

At KPNW, constantly improving service quality is an ongoing goal. To that end, key operational processes that impact member satisfaction, access to services, wait times, telephone access, and physician communication are reviewed, assessed, and monitored regularly. KPNW uses various surveys to obtain members satisfaction data for care access, services received, and overall care experience. Beginning in 1999, the NCQA began requiring accredited health plans to conduct the Consumer Assessment of Health Plans Study (CAHPS) each year as part of the NCQA accreditation process. CAHPS standardizes the measurement of member perceptions and experience across health plans throughout the nation. The results are important not only for NCQA accreditation, but because they provide important feedback to our organization, our employer groups, and other purchasers of the Kaiser Permanente health plan.
The tables below show 2017 Commercial CAHPS results for KPNW as compared with 2016:

<table>
<thead>
<tr>
<th>Commercial: CAHPS Overall Rating *</th>
<th>2017 Percentile Ranking</th>
<th>2016 Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal doctor</td>
<td>59% 5th</td>
<td>63% 25th</td>
</tr>
<tr>
<td>Specialist</td>
<td>63% 10th</td>
<td>60% 10th</td>
</tr>
<tr>
<td>Health care</td>
<td>45% 10th</td>
<td>47% 25th</td>
</tr>
<tr>
<td>Health plan</td>
<td>44% 75th</td>
<td>44% 75th</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commercial: Composite Measures#</th>
<th>2017 Percentile Ranking</th>
<th>2016 Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting needed care</td>
<td>78% &gt;5th</td>
<td>86% 10th</td>
</tr>
<tr>
<td>Getting care quickly</td>
<td>77% 5th</td>
<td>85% 33rd</td>
</tr>
<tr>
<td>How well doctors communicate</td>
<td>94% 10th</td>
<td>94% 25th</td>
</tr>
<tr>
<td>Customer service</td>
<td>87% 25th</td>
<td>88% 75th</td>
</tr>
</tbody>
</table>

* reflects members who rated question a 9–10 on a scale of 0–10
# reflects members who responded “usually” or “always”

The table below shows 2017 Medicare CAHPS (2018 Star Ratings) results for KPNW as compared with 2016 Medicare CAHPS (2017 Star Ratings) results:

<table>
<thead>
<tr>
<th>CMS Star Ratings:</th>
<th>2018 SRs Final Score</th>
<th>2018 SRs Final Stars</th>
<th>2017 SRs Final Score</th>
<th>2017 SRs Final Stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Flu Vaccine</td>
<td>80% 5</td>
<td>85 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ease of Getting Needed Care and Seeing Specialists</td>
<td>83% 3</td>
<td>83 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting Appointments and Care Quickly</td>
<td>80% 4</td>
<td>80 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer Service</td>
<td>91% 4</td>
<td>91 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Health Care Quality</td>
<td>88% 5</td>
<td>88 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members’ Rating of Health Plan</td>
<td>90% 5</td>
<td>90 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>85% 3</td>
<td>83 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members’ Rating of Drug Plan</td>
<td>91% 5</td>
<td>91 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting Needed Prescription Drugs</td>
<td>94% 5</td>
<td>95 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The CAHPS survey responses are case-mix adjusted to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses, and they are then mapped to a 0-100 scale to create the measure scores.

Among other surveys fielded to assess member satisfaction are the Medical Office Visit (MOV) survey that monitors patient satisfaction with outpatient services at the department level; Member Experience: Tracking Evaluation and Opinion Research (METEOR) that monitors member satisfaction with the quality of service and medical care, access to care, and overall satisfaction with KFHP-NW; and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).
Disease Management aims to measurably reduce the complications with selected chronic diseases and to enhance patients’ health and quality of life through a coordinated set of evidence-based interventions. KPNW offers disease management programs to target individuals with a specific disease such as asthma, diabetes, cardiovascular disease and congestive heart failure. Interventions for each program are based on risk stratification. Patients enrolled in any of the disease management programs receive education and self-care tools to help better manage their conditions, some may also receive case management services depending on need.

Members are identified for participation in the respective disease management program through methods such as claims and provider referrals. Eligible members are enrolled in these programs using an opt-out method and added to the disease management registries of the respective programs. We want you to be aware of these services so that you can integrate them with your clinical practice and facilitate member participation.

To refer a member or find out more about any of the disease management programs, case management, or other population care initiatives, contact Clinical Quality Support Services toll free at 855-517-8382.

Members may be dis-enrolled upon their request or the request of their primary care clinician by contacting Clinical Quality Support Services.
Complex case management

Our regional team of Complex Case Managers is available to assist with your complex, chronic medical patients. Complex Case Management is for members who may have experienced a critical event or diagnosis, are medically complex or resource intensive and need help navigating the system. The program has been designed to meet NCQA accreditation standards and to support Kaiser Members for anywhere from three to six months. Members enrolled in the Program set their own goals and work intensively with a RN Case Manager to make progress toward improved health and functional capability.

If you have a patient that meets criteria outlined below and might benefit from the program you can refer them by calling 855-517-8382. An RN from the Quality Department will screen the referrals for appropriateness and if the patient meets criteria they will be enrolled in the program. If your patient needs urgent or immediate assistance, this would not be the appropriate referral.

Below are the inclusion/exclusion criteria for Complex Case Management Program. When referring, please specify the focus/reason the patient is being referred, along with a corresponding diagnosis.

**Inclusion criteria:**

Patient is a member of Kaiser Health Plan, and meets **ONE** of the following characteristics:

- Frequent Hospitalizations: >/= 2 in a 3 month period, OR
- **One hospitalization with discharge to SNF in a 3 month period**, OR
- Frequent ED visits >/= 4 visits in a 3 month period

**Additional consideration is made for members who may not exactly meet the criteria listed above, however demonstrate a need for stabilization in order to avoid further utilization of hospital or clinic services.**

**Exclusion criteria:**

- Active Chemical Abuse/Substance Abuse where the member has not adhered to their care plan.
- Mental Health disorders without Medical Dx, or without the ability to engage in CCM activities.
- When telephonic case management is not possible.
- Oncology patients in Active Chemotherapy with Kaiser Oncologist.
- Managed by an inclusive case management program such as: Hospice/Palliative Care, GLTC or KPEDU
KPNW supports the development and use of evidence-based clinical practice guidelines and practice resources to aid clinicians and members in the selection of the best prevention, screening, diagnostic, and treatment options. The best options are those that are backed by high-quality evidence, provide net clinical benefit (the balance between benefits and harms), respect members values and preferences, and use resources equitable and efficiently.

The KP guidelines recommend the preferred course of action while recognizing the role of clinical judgment and informed decision making in determining exceptions.

For more information on clinical practice guidelines and practice resources, contact the Guidelines and Evidence-Based Medicine Department via the information below:

- Andrew Felcher MD, Director / andrew.h.felcher@kp.org / 503-813-2663
- Heather L Smith, Clinical Guidelines Content Manager / heather.l.smith@kp.org / 503-813-3820

Grievances and appeals

Member complaints, grievances, and appeals

If members are dissatisfied with their care, they are encouraged to discuss this with their provider as soon as possible. For other problems with care or service, they are asked to speak with a facility administrator. Members may also contact Member Services at any of our facilities or via the Member Services Call Center (at 503-813-2000 in Portland and 1-800-813-2000 in all other areas) to voice complaints. Member Services representatives will advise members about our resolution process and ensure the appropriate parties review the member’s complaint. Every attempt is made to resolve the concern promptly. Members or the member’s representative may file a written grievance if not satisfied with our response. They may appeal to have a complaint, grievance or adverse determination reviewed again. Members are notified of these processes in their Explanation of Coverage or Benefit Booklet, distributed annually.

Expedited reviews

Initial requests, grievances, and appeals are expedited according to the clinical urgency of the situation. Requests will also be expedited if a physician states a need based on the member’s medical condition.

Independent medical review

If the appeal process within Kaiser Permanente has been exhausted, an appeal may be eligible for an independent review. If the member’s case qualifies for an independent medical review, medical experts not affiliated with Kaiser Permanente will conduct the review. There is no charge to the member for this review, and Kaiser Permanente will honor the decision made by the IRO. When an appeal is denied, the independent review process is outlined in the member’s appeal denial letter.

Contacting Membership Services by phone

503-813-2000 in Portland and 1-800-813-2000 in all other areas.

Contacting Membership Services in writing

Attn: Membership Services
Kaiser Permanente
500 NE Multnomah St., Ste. 100
Portland, OR 97232